

14077
State File No.....

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BIRTH NO. _____ REG. DIST. NO. 197 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1971

1. PLACE OF DEATH *Childrens Mercy Hospital* USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. COUNTY *Le* a. STATE *Missouri* b. COUNTY *St. Louis*

| | | | | |
|--------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Haverhill | | c. LENGTH OF STAY (In this place) 13 days | c. CITY OR TOWN St. Joseph | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
|--------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|

d. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION Childrens Mercy Hospital

e. STREET ADDRESS (If rural, give location)
Route 2

| | | | | |
|----------------------------------------|------------|-------------|-----------|------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) | b. (Middle) | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
| | Raymond | Earl | Butler | |

| | | | | | | |
|----------------|---------------------------|--------------------------------------------------------------------|----------------------------------|-----------------------------------------|---------------------------------------|--------------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child | 8. DATE OF BIRTH Dec. 3, 1947 | 9. AGE (in years last birthday) 5 | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 1 YEAR Hours Min. |
|----------------|---------------------------|--------------------------------------------------------------------|----------------------------------|-----------------------------------------|---------------------------------------|--------------------------------------|

| | | | |
|---------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------|------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) | 12. CITIZEN OF WHAT COUNTRY? |
| None | None | Stockton, Calif. | U.S.A. |
| 13. FATHER'S NAME | 13b. MOTHER'S MAIDEN NAME | 14. NAME OF HUSBAND OR WIFE | |

| | | |
|---------------------------------------------|-------------------------------------------------|---------------------------------------------|
| 13A. FATHER'S NAME Raymond Butler | 13B. MOTHER'S MATHEN NAME Evelyn Roup | 14. NAME OF HUSBAND OR WIFE none |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY | 17. INFORMANT'S SIGNATURE OR NAME & ADDRESS |

| | | | |
|----------------------------------------------------------------------------|--|----------------------------------------------|--|
| (Yes, no, or unknown) no. (If yes, give war or dates of service) | | NO. 1 rather Raymond Butler | |
| 18. CAUSE OF DEATH | | MEDICAL CERTIFICATION | |
| 19. DATE OF DEATH | | INTERVAL BETWEEN | |

Enter only one cause per line for (a), (b), and (c)

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction & Chronic Leukemia

ANTECEDENT CAUSES

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease.

| | | |
|------------------------------------------------------------------|------------|------|
| case, or disease, or injury, or complication which caused death. | DUE TO (c) | |
| II. OTHER SIGNIFICANT CONDITIONS | | |
| Conditions contributing to the death but not | | 2044 |

| | | |
|----------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------|
| related to the disease or condition causing death. | | ✓ |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | | | |
|------------------------------------------|--|------------------------------------------------------------------------------------------|-------------------------------------------------|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|------------------------------------------|--|------------------------------------------------------------------------------------------|-------------------------------------------------|

| | | | | | | |
|---------------------|---------|-------|--------|--------|-----------------------------------------------------------------------------------|----------------------------|
| 21d. TIME OF INJURY | (Month) | (Day) | (Year) | (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
| | | | | m. | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |

22. I hereby certify that I attended the deceased from 3-16, 1953, to 4-13, 1953, that I last saw the deceased alive on 4-13, 1953, and that death occurred at 5:30 A. m., from the causes and on the date stated above.

| | | | | |
|----------------|---------------------|-------------------|-----------------------|------------------|
| 23a. SIGNATURE | H. M. Gilkey | (Degree or title) | 23b. ADDRESS | 23c. DATE SIGNED |
| | <i>H. M. Gilkey</i> | <i>M.D.</i> | <i>1624 Prof Bldg</i> | <i>4/13/53</i> |

| | | | | |
|-------------------------------------------|-----------------------|----------------------------------------|--------------------------------------|---------|
| 24a. BURIAL CREMATATION REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City/Town, or county) | (State) |
| Removal | 4-13-53 | Savannah, Mo. | | |
| DATE RECD BY LOCAL | REGISTERING SIGNATURE | 25. FINAL DIRECTOR'S SIGNATURE ADDRESS | | |

DATE REC'D BY LOCAL REG. 4-13-53 REGISTRAR'S SIGNATURE *Geraldine Smith* 23. FURNER'S DIRECTOR'S SIGNATURE *Hester Bannan* 3/15/54 ADDRESS *214 1/2 W. 1st St. N. Fargo, N.D.*
(Licensed Embalmer's Statement on Reverse Side)

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *W E Elmington*

Licensed Embalmer No. *479*

P. O. Address *519 So 10*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.